



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-17-2540-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility separate amount. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: \$898.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 12/7/2016.

The requestor wants payment for code 73080. This code has status indicator Q1, which states, 'Packaged APC payment if billed on the same date of service as HCPS code assigned status indicator 'S', 'T', or 'V'."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 07, 2016 to December 08, 2016	Outpatient Hospital Services	\$898.38	\$4.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED
 - 616 – THIS CODE AHS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS
 - CAC-P12 – WORKERS' COMPENSATION JURISIDCTIONAL FEE SCHEDULE ADJUSTMENT
 - 767 – PAID PER O/P FG AT 200% IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE
 - 236 – THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS/FEE SCHEDULE REQUIREMENTS
 - 435 – PER CCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE
 - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL AHS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERAITON OR APPEAL
 - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, TI WAS DETERMIEND THAT THIS CLAIM WAS PROCESSED PROPERLY
 - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
 - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERAITON OR APPEAL
 - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code C1713 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code G0478 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 87070 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 87075 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 87205 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 87077 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 73080 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 20680 has status indicator Q2, denoting T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. These services are separately paid only if no other such procedures are billed.
- Procedure code 24300 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5113. The OPPS Addendum A rate is \$1,096.45. This is multiplied by 60% for an unadjusted labor-related amount of \$657.87, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of \$528.01. The non-labor related portion is 40% of the APC rate, or \$438.58. The sum of the labor and non-labor portions is \$966.59. The cost of these services does not exceed the fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific amount of \$966.59, is multiplied by 200% for a MAR of \$1,933.18.
- Procedure code J2250 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2765 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2270 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J1100 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J3010 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J0330 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

- Procedure code J1885 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J2710 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J2370 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code J2175 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
 - Procedure code A9270 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
 - Procedure code A9270 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
 - Per Medicare policy, procedure code 96374 may not be reported with procedure code 24300 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
4. The total recommended reimbursement for the disputed services is \$1,933.18. The insurance carrier has paid \$1,928.31 leaving an amount due to the requestor of \$4.87. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4.87.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$4.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/19/2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.